FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042044

Facility Name: WASHINGTON HEIGHTS N H

Address: 1010 WEST 95TH ST (Number) CHICAGO (City) 60643 (Zip Code)

County: COOK

Telephone Number: (773) 298-1177 **Fax #** (773) 298-1666

IDPA ID Number: 364100431001

Date of Initial License for Current Owners: 10/24/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) EDWARD N. SLACK, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	228	Skilled (SNF)	228	83,220	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	228	TOTALS	228	83,220	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,090	246	4,651	10,987	8
9	SNF/PED					9
10	ICF	62,000	3,192	60	65,252	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	68,090	3,438	4,711	76,239	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.61%

D. How many bed-hold days during this year were paid by Public Aid?
2560 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/24/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/24/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 4588

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	322,760	47,319	21,502	391,581		391,581	(3,086)	388,495			1
2	Food Purchase		279,605		279,605	(34,821)	244,784	3,404	248,188			2
3	Housekeeping	202,224	63,273		265,497		265,497	2,371	267,868			3
4	Laundry	88,884	22,997		111,881		111,881		111,881			4
5	Heat and Other Utilities			307,234	307,234		307,234	3,141	310,375			5
6	Maintenance	77,647		330,521	408,168		408,168	(660)	407,508			6
7	Other (specify):*							2,667	2,667			7
8	**TOTAL General Services**	691,515	413,194	659,257	1,763,966	(34,821)	1,729,145	7,838	1,736,983			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	2,554,234	102,367	77,374	2,733,975		2,733,975	20,091	2,754,066			10
10a	Therapy	77,343	3,343	10,546	91,232		91,232	1,396	92,628			10a
11	Activities	128,951	8,429	6,396	143,776		143,776	(1,230)	142,547			11
12	Social Services	87,688		5,414	93,102		93,102	(2,835)	90,267			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							13,841	13,841			15
16	**TOTAL Health Care and Programs**	2,848,216	114,139	108,730	3,071,085		3,071,085	31,264	3,102,349			16
	C. General Administration											
17	Administrative	64,361		278,286	342,647		342,647	57,215	399,862			17
18	Directors Fees											18
19	Professional Services			402,286	402,286	(9,696)	392,590	(304,611)	87,979			19
20	Dues, Fees, Subscriptions & Promotions			73,695	73,695		73,695	(40,202)	33,493			20
21	Clerical & General Office Expenses	128,273	23,621	210,125	362,019		362,019	8,270	370,289			21
22	Employee Benefits & Payroll Taxes			644,286	644,286	34,821	679,107	(34,026)	645,081			22
23	Inservice Training & Education			456	456		456		456			23
24	Travel and Seminar			2,947	2,947		2,947	1,660	4,607			24
25	Other Admin. Staff Transportation			9,919	9,919		9,919	(9,225)	694			25
26	Insurance-Prop.Liab.Malpractice			322,113	322,113		322,113	1,609	323,722			26
27	Other (specify):*							33,919	33,919			27
28	**TOTAL General Administration**	192,634	23,621	1,944,113	2,160,368	25,125	2,185,493	(285,391)	1,900,102			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,732,365	550,954	2,712,100	6,995,419	(9,696)	6,985,723	(246,289)	6,739,434			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WASHINGTON HEIGHTS N H #0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			51,143	51,143		51,143	579,031	630,174			30
31	Amortization of Pre-Op. & Org.			2,944	2,944		2,944	556	3,500			31
32	Interest			56,457	56,457		56,457	740,431	796,888			32
33	Real Estate Taxes			326,846	326,846	9,696	336,542	4,557	341,099			33
34	Rent-Facility & Grounds			1,266,222	1,266,222		1,266,222	(1,259,967)	6,255			34
35	Rent-Equipment & Vehicles			3,617	3,617		3,617	4,722	8,339			35
36	Other (specify):*											36
37	TOTAL Ownership			1,707,229	1,707,229	9,696	1,716,925	69,330	1,786,255			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		199,592	116,032	315,624		315,624	(8,509)	307,115			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			124,830	124,830		124,830		124,830			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		199,592	240,862	440,454		440,454	(8,509)	431,945			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,732,365	750,546	4,660,191	9,143,102		9,143,102	(185,469)	8,957,633			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	252,579	30		9
10	Interest and Other Investment Income	(175,496)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(125)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(84,000)	21		24
25	Fund Raising, Advertising and Promotional	(17,281)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,000)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(264)	20		28
29	Other-Attach Schedule	(26,131)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (57,718)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(127,751)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (127,751)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (185,469)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

WASHINGTON HEIGHTS N H

ID# 0042044

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	AMORTIZATION OLD LOAN FEES-BLDG	$ (9,493)	31	1
2	LLC FEE - BLDG	(200)	20	2
3	ADDITIONAL LEGAL FEES NOT IN TB	10,795	19	3
4	COLLECTION	(5,606)	21	4
5	BANK CHARGES	(2,731)	21	5
6	THEFT LOSS	(6,030)	21	6
7	IL COUNCIL (COPE)	(4,142)	20	7
8	PP DEPRECIATION ADJ	(5,632)	30	8
9	NON ALLOWABLE LEGAL	(2,092)	19	9
10	SURVEY	(1,000)	19	10
11				11
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			6,062	(8,322)		(826)						(3,086)	1
2	Food Purchase	(125)		(570)			4,099						3,404	2
3	Housekeeping			2,371									2,371	3
4	Laundry													4
5	Heat and Other Utilities			3,141									3,141	5
6	Maintenance			17,402	(18,063)		1						(660)	6
7	Other (specify):*			2,456			211						2,667	7
8	**TOTAL General Services**	(125)		30,862	(26,385)		3,485						7,838	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			35,512	(70,518)	63,459	38	(8,400)					20,091	10
10a	Therapy			7,079	(5,683)								1,396	10a
11	Activities			2,742	(3,972)								(1,230)	11
12	Social Services			2,579	(5,414)								(2,835)	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			6,092		7,749							13,841	15
16	**TOTAL Health Care and Programs**			54,004	(85,586)	71,208	38	(8,400)					31,264	16
	C. General Administration													
17	Administrative			57,115	(72,852)	72,852	100						57,215	17
18	Directors Fees													18
19	Professional Services	7,703		8,372	(320,705)		19						(304,611)	19
20	Fees, Subscriptions & Promotions	(21,887)	200	2,281	(20,805)		9						(40,202)	20
21	Clerical & General Office Expenses	(105,367)		163,803	(50,342)		176						8,270	21
22	Employee Benefits & Payroll Taxes				(34,026)								(34,026)	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,659			1						1,660	24
25	Other Admin. Staff Transportation			89	(9,516)		202						(9,225)	25
26	Insurance-Prop.Liab.Malpractice			1,609									1,609	26
27	Other (specify):*			24,830		9,089							33,919	27
28	**TOTAL General Administration**	(119,551)	200	259,758	(508,246)	81,941	507						(285,391)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(119,676)	200	344,624	(620,217)	153,149	4,030	(8,400)					(246,289)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	246,947	319,786	12,298									579,031	30
31	Amortization of Pre-Op. & Org.	(9,493)	10,049										556	31
32	Interest	(175,496)	903,053	12,871			3						740,431	32
33	Real Estate Taxes			4,557									4,557	33
34	Rent-Facility & Grounds		(1,266,222)	6,255									(1,259,967)	34
35	Rent-Equipment & Vehicles			4,711			11						4,722	35
36	Other (specify):*													36
37	TOTAL Ownership	61,958	(33,334)	40,692			14						69,330	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(6,027)	(2,482)					(8,509)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(6,027)	(2,482)					(8,509)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(57,718)	(33,134)	385,316	(620,217)	153,149	(1,983)	(10,882)					(185,469)	45

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		
				WASHINGTON HEIGHTS PROPERTY, LLC		BUILDING CO.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 1,266,222	WASHINGTON HEIGHTS PROPERTY, LLC.		$	$ (1,266,222)	1
2	V	32	INTEREST	54,067	WASHINGTON HEIGHTS PROPERTY, LLC.		957,120	903,053	2
3	V	31	AMORTIZATION		WASHINGTON HEIGHTS PROPERTY, LLC.		10,049	10,049	3
4	V	30	DEPRECIATION		WASHINGTON HEIGHTS PROPERTY, LLC.		319,786	319,786	4
5	V	20	LLC FEE		WASHINGTON HEIGHTS PROPERTY, LLC.		200	200	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,320,289			$ 1,287,155	$ * (33,134)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS, INC.	100.00%	$ 6,062	$ 6,062	15
16	V	2	FOOD				(570)	(570)	16
17	V	3	HOUSEKEEPING				2,371	2,371	17
18	V	5	UTILITIES				3,141	3,141	18
19	V	6	REPAIRS AND MAINT.				17,402	17,402	19
20	V	7	EMP. BEN. - GEN. SERV.				2,456	2,456	20
21	V	10	NURSING				35,512	35,512	21
22	V	10A	THERAPY				7,079	7,079	22
23	V	11	ACTIVITIES				2,742	2,742	23
24	V	12	SOCIAL SERVICES				2,579	2,579	24
25	V	15	EMP. BEN. - HEALTHCARE				6,092	6,092	25
26	V	17	ADMINISTRATIVE				57,115	57,115	26
27	V	19	PROFESSIONAL FEES				8,372	8,372	27
28	V	20	DUES, SUBSCRIPTIONS				2,281	2,281	28
29	V	21	CLERICAL AND GENERAL				163,803	163,803	29
30	V	24	SEMINARS				1,659	1,659	30
31	V	25	AUTO EXPENSE				89	89	31
32	V	26	INSURANCE				1,609	1,609	32
33	V	27	EMP. BEN. - GEN. ADMIN.				24,830	24,830	33
34	V	30	DEPRECIATION				12,298	12,298	34
35	V	32	INTEREST				12,871	12,871	35
36	V	33	REAL ESTATE TAXES				4,557	4,557	36
37	V	34	BUILDING RENT - UNRELATED				6,255	6,255	37
38	V	35	EQUIPMENT RENTAL				4,711	4,711	38
39	Total			$			$ 385,316	$ * 385,316	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY CONS	$ 8,322	CARE CENTERS, INC.	100.00%	$	$ (8,322)	15
16	V	19	ACCOUNTING	15,000				(15,000)	16
17	V	19	ANCIL ADMIN FEE	27,360				(27,360)	17
18	V	19	BOOKEEPING	46,512				(46,512)	18
19	V	19	DATA PROCESSING	8,208				(8,208)	19
20	V	19	LEGAL	20,805				(20,805)	20
21	V	19	MANAGEMENT FEE	191,520				(191,520)	21
22	V	19	PROFESSIONAL FEES	11,300				(11,300)	22
23	V	20	ADVERTISING	20,805				(20,805)	23
24	V	25	REBILL BUS	9,516				(9,516)	24
25	V								25
26	V	22	HOME OFFICE PAYROLL TAX	34,026				(34,026)	26
27	V	1	REBILL. PAYROLL DIETARY						27
28	V	3	REBILL. PAYROLL HSKPNG						28
29	V	6	REBILL. PAYROLL MAINT.	18,063				(18,063)	29
30	V	10	REBILL. PAYROLL NURSING	70,518				(70,518)	30
31	V	10A	REBILL. PAYROLL THPY CONS.	5,683				(5,683)	31
32	V	11	REBILL. PAYROLL ACTIVITIES	3,972				(3,972)	32
33	V	12	REBILL. PAYROLL SOC. SERV.	5,414				(5,414)	33
34	V	17	REBILL. PAYROLL ADMIN.	72,852				(72,852)	34
35	V	21	REBILL. PAYROLL CLERICAL	50,342				(50,342)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 620,217			$	$ * (620,217)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$	CARE CENTERS, INC.	100.00%	$ 63,459	$ 63,459	15
16	V	15	EMP. BEN HEALTHCARE				7,749	7,749	16
17	V	17	ADMINISTRATIVE				72,852	72,852	17
18	V	27	EMP. BEN GEN. ADMIN.				9,089	9,089	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 153,149	$ * 153,149	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	$ 2,316	$ 2,316	15
16	V	2	FOOD				4,099	4,099	16
17	V	6	MAINTENANCE				1	1	17
18	V	7	EMP. BEN. - GEN. SERV.				211	211	18
19	V	10	NURSING				38	38	19
20	V	17	ADMINISTRATIVE				100	100	20
21	V	19	PROFESSIONAL FEES				19	19	21
22	V	20	DUES, FEES, SUB.				9	9	22
23	V	21	CLERICAL & GENERAL				176	176	23
24	V	24	SEMINARS				1	1	24
25	V	25	TRAVEL				202	202	25
26	V	32	INTEREST				3	3	26
27	V	35	RENT - EQUIPMENT & VEHICLES				11	11	27
28	V	39	ANCILLARY ENTERAL SUPPLIES				134	134	28
29	V	1	DIETARY SUPP	3,142				(3,142)	29
30	V	39	ANCILLARY SUPP	6,161				(6,161)	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,303			$ 7,320	$ * (1,983)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICAL SUPPLIES	$	XCEL MEDICAL SUPPLLY LLC	100.00%	$ 69,159	$ 69,159	15
16	V	39	MEDICAL SUPPLIES				20,439	20,439	16
17	V								17
18	V								18
19	V	10	MEDICAL SUPPLIES	77,559				(77,559)	19
20	V	39	MEDICAL SUPPLIES	22,921				(22,921)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 100,480			$ 89,598	$ * (10,882)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 64,903	$ 64,903	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	64,903				(64,903)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 64,903			$ 64,903	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	DAVID ARONIN	OWNER	Administrative	0.89%	See Attached	2.50	5.00%	Alloc Salary	$ 4,358	17-7	1
2	ARIEL GOLDBERG	RELATIVE	Clerical	0%	See Attached	.22	5.03%	Alloc Salary	125	21-7	2
3	ZEV GOLDBERG	RELATIVE	Clerical	0%	See Attached	1.29	5.02%	Alloc Salary	837	21-7	3
4	NORMAN GOLDBERG	OWNER	Administrative	1.77%	See Attached	2.50	5.00%	Alloc Salary	5,054	17-7	4
5	RON ABRAMS	OWNER	Administrative	8.85%	See Attached	1.00	2.86%	Mgt. Fee	12,000	17-3	5
6	ALAN ABRAMS	OWNER	Administrative	8.85%	See Attached	1.00	2.86%	Mgt. Fee	12,000	17-3	6
7	MARK STEINBERG	RELATIVE	Administrative	0%	See Attached	2.50	5.00%	Alloc Salary	2,225	17-7	7
8	ERIC ROTHNER	RELATIVE	Administrative	0%	See Attached	2.45	3.40%	Mgt. Fee	180,000	17-3	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 216,599		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	1,522,375	33	$ 121,047	$ 120,871	76,239	$ 6,062	1
2	2	FOOD	PATIENT DAYS	1,522,375	33	(11,374)		76,239	(570)	2
3	3	HOUSEKEEPING	PATIENT DAYS	1,522,375	33	47,342	43,569	76,239	2,371	3
4	5	UTILITIES	PATIENT DAYS	1,522,375	33	62,714		76,239	3,141	4
5	6	REPAIRS AND MAINT.	PATIENT DAYS	1,522,375	33	347,481	212,397	76,239	17,402	5
6	7	EMP. BEN. - GEN. SERV.	PATIENT DAYS	1,522,375	33	49,052		76,239	2,456	6
7	10	NURSING	PATIENT DAYS	1,522,375	33	709,129	712,466	76,239	35,512	7
8	10A	THERAPY	PATIENT DAYS	1,522,375	33	141,364	140,790	76,239	7,079	8
9	11	ACTIVITIES	PATIENT DAYS	1,522,375	33	54,745	53,877	76,239	2,742	9
10	12	SOCIAL SERVICES	PATIENT DAYS	1,522,375	33	51,491	51,491	76,239	2,579	10
11	15	EMP. BEN. - HEALTHCARE	PATIENT DAYS	1,522,375	33	121,645		76,239	6,092	11
12	17	ADMINISTRATIVE	PATIENT DAYS	1,522,375	33	1,140,506	1,135,183	76,239	57,115	12
13	19	PROFESSIONAL FEES	PATIENT DAYS	1,522,375	33	167,175		76,239	8,372	13
14	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	1,522,375	33	45,541		76,239	2,281	14
15	21	CLERICAL AND GENERAL	PATIENT DAYS	1,522,375	33	3,270,885	2,869,864	76,239	163,803	15
16	24	SEMINARS	PATIENT DAYS	1,522,375	33	33,128		76,239	1,659	16
17	25	AUTO EXPENSE	PATIENT DAYS	1,522,375	33	1,780		76,239	89	17
18	26	INSURANCE	PATIENT DAYS	1,522,375	33	32,120		76,239	1,609	18
19	27	EMP. BEN. - GEN. ADMIN.	PATIENT DAYS	1,522,375	33	495,816		76,239	24,830	19
20	30	DEPRECIATION	PATIENT DAYS	1,522,375	33	245,564		76,239	12,298	20
21	32	INTEREST	PATIENT DAYS	1,522,375	33	257,009		76,239	12,871	21
22	33	REAL ESTATE TAXES	PATIENT DAYS	1,522,375	33	91,002		76,239	4,557	22
23	34	BUILDING RENT - UNRELATE	PATIENT DAYS	1,522,375	33	124,898		76,239	6,255	23
24	35	EQUIPMENT RENTAL	PATIENT DAYS	1,522,375	33	94,062		76,239	4,711	24
25	TOTALS					$ 7,694,122	$ 5,340,509		$ 385,316	25

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT ALLOCATION		7	384,296	384,296		63,459	1
2	15	EMP. BEN HEALTHCARE	DIRECT ALLOCATION		7	49,011			7,749	2
3	17	ADMINISTRATIVE	DIRECT ALLOCATION		27	1,367,742	1,367,742		72,852	3
4	27	EMP. BEN GEN. ADMIN.	DIRECT ALLOCATION		27	180,242			9,089	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,981,291	$ 1,752,038		$ 153,149	25

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	HEALTH SYSTEMS INC.	2,322,899	28	578,157	413,013	9,303	2,316	1
2	2	FOOD	HEALTH SYSTEMS INC.	2,322,899	28	1,023,347		9,303	4,099	2
3	6	MAINTENANCE	HEALTH SYSTEMS INC.	2,322,899	28	185		9,303	1	3
4	7	EMP. BEN. - GEN. SERV.	HEALTH SYSTEMS INC.	2,322,899	28	52,590		9,303	211	4
5	10	NURSING	HEALTH SYSTEMS INC.	2,322,899	28	9,570		9,303	38	5
6	17	ADMINISTRATIVE	HEALTH SYSTEMS INC.	2,322,899	28	25,000		9,303	100	6
7	19	PROFESSIONAL FEES	HEALTH SYSTEMS INC.	2,322,899	28	4,819		9,303	19	7
8	20	DUES, FEES, SUB.	HEALTH SYSTEMS INC.	2,322,899	28	2,196		9,303	9	8
9	21	CLERICAL & GENERAL	HEALTH SYSTEMS INC.	2,322,899	28	43,980		9,303	176	9
10	24	SEMINARS	HEALTH SYSTEMS INC.	2,322,899	28	257		9,303	1	10
11	25	TRAVEL	HEALTH SYSTEMS INC.	2,322,899	28	50,512		9,303	202	11
12	32	INTEREST	HEALTH SYSTEMS INC.	2,322,899	28	801		9,303	3	12
13	35	RENT - EQUIPMENT & VEHICI	HEALTH SYSTEMS INC.	2,322,899	28	2,624		9,303	11	13
14	39	ANCILLARY ENTERAL SUPPL	HEALTH SYSTEMS INC.	2,322,899	28	33,430		9,303	134	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,827,468	$ 413,013		$ 7,320	25

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY LLC
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-2330
Fax Number: (708)449-3236

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICAL SUPPLIES	DIRECT ALLOCATION			$	$		$ 69,159	1
2	39	MEDICAL SUPPLIES	DIRECT ALLOCATION						20,439	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 89,598	25

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 64,903	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 64,903	25

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	CORUS BANK	X		MORTGAGE			$	$ 12,451,059			$ 957,120	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 12,451,059			$ 957,120	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(160,232)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (160,232)	14
15	TOTALS (line 9+line14)						$	$ 12,451,059			$ 796,888	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	CANAWELL INTEREST		X				$	$			$ 2,390	1
2	ALLOC CCI	X									12,871	2
3	ALLOC CCI-HEALTH SYS.	X									3	3
4	INTEREST INCOME										(175,496)	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (160,232)	21

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	371,545	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	342,474	2
3. Under or (over) accrual (line 2 minus line 1).	$	(29,071)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	360,474	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	9,696	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	341,099	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	88,579	8
	1997	349,971	9
	1998	356,222	10
	1999	353,852	11
	2000	337,917	12

2001 ACCRUAL = 2000 RE TAX BILL $343308.68 X 1.05=$360474

ALLOCATION FROM CARE CENTERS = $4557

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WASHINGTON HEIGHTS N H COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0042044

CONTACT PERSON REGARDING THIS REPORT STEVEN LAVENDA

TELEPHONE (847) 236 - 1111 FAX #: (847) 236 - 1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	25-05-423-001-0000	LTC PROPERTY	$ 1,287.17	$ 1,287.17
2.	25-05-423-002-0000	LTC PROPERTY	$ 1,420.98	$ 1,420.98
3.	25-05-423-003-0000	LTC PROPERTY	$ 1,627.42	$ 1,627.42
4.	25-05-423-004-0000	LTC PROPERTY	$ 1,575.15	$ 1,575.15
5.	25-05-423-005-0000	LTC PROPERTY	$ 8,139.36	$ 8,139.36
6.	25-05-423-006-0000	LTC PROPERTY	$ 41,631.32	$ 41,631.32
7.	25-05-423-007-0000	LTC PROPERTY	$ 50,201.27	$ 50,201.27
8.	25-05-423-008-0000	LTC PROPERTY	$ 129,649.42	$ 129,649.42
9.	25-05-423-009-0000	LTC PROPERTY	$ 102,385.33	$ 102,385.33
10.	SEE ATTACHED	HOME OFFICE ALLOCATION	$ 66,986.83	$ 3,354.63
		TOTALS	$ 404,904.25	$ 341,272.05

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 90,255 B. General Construction Type: Exterior BRICK Frame MASONRY & STEEL Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 3,309
2. Number of Years Over Which it is Being Amortized: 2yrs
3. Current Period Amortization: 3,500
4. Dates Incurred: 1996

Nature of Costs: Financing Fees
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	85,244	1994	$ 251,898	1
2	ALLOC CCI			3,205	2
3	TOTALS	85,244		$ 255,103	3

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1996	21,522			1,077	1,077	5,874	9
10	Various			1997	179,381			8,971	8,971	39,948	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		10,297,658	264,097		513,708	249,611	2,682,255	68
69	Financial Statement Depreciation			45,512			(45,512)		69
70	TOTAL (lines 4 thru 69)		$ 10,498,561	$ 309,609		$ 523,756	$ 214,147	$ 2,728,077	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 10,498,561	$ 309,609		$ 523,756	$ 214,147	$ 2,728,077	1
2	ELECTRICAL	1998	782			39	39	156	2
3	PAINT	1998	532			27	27	106	3
4	ENTRANCE DOOR	1998	2,040			102	102	400	4
5	PLUMBING RENOV.	1998	2,095			105	105	403	5
6	CARPETING	1998	12,575			629	629	2,411	6
7	FLOOR REPAIRS	1998	1,400			70	70	263	7
8	POWER SUPP. LINE	1998	1,046			52	52	195	8
9	SECURITY SYSTEM	1998	4,345			217	217	814	9
10	SECURITY SYSTEM	1998	4,150			208	208	763	10
11	ELECTRICAL	1998	581			29	29	106	11
12	SECURITY	1998	2,800			140	140	502	12
13	ELECTRICAL	1998	605			30	30	108	13
14	PANELING	1998	987			49	49	172	14
15	EXHAUST FAN	1998	652			33	33	116	15
16	ELEV RENOV	1998	1,594			80	80	280	16
17	SLAB	1998	1,600			80	80	280	17
18	TILING	1998	538			27	27	95	18
19	LANDSCAPING	1998	6,654			333	333	1,138	19
20	REPLACE DUCT	1998	772			39	39	133	20
21	BOILER	1998	545			27	27	92	21
22	DOORS	1998	1,261			63	63	210	22
23	SYSTEM TREATMENT	1998	4,946			247	247	823	23
24	AUTO DRAIN	1998	681			34	34	113	24
25	FIRE ALARM	1998	961			48	48	160	25
26	PLASTER	1998	650			33	33	107	26
27	LANDSCAPING	1998	3,705			185	185	601	27
28	MONITOR SYSTEM	1998	6,435			322	322	1,047	28
29	ART	1998	671			34	34	108	29
30	AVAIRY	1998	4,409			220	220	697	30
31	CERTIFICATE OF NEED	1998	1,881			94	94	282	31
32	DOOR	1999	1,064			53	53	159	32
33	PLUMBING RENOV	1999	2,727			136	136	374	33
34	TOTAL (lines 1 thru 33)		$ 10,574,245	$ 309,609		$ 527,541	$ 217,932	$ 2,741,291	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 10,574,245	$ 309,609		$ 527,541	$ 217,932	$ 2,741,291	1
2	SIGN OVERHANG	1999	1,750			88	88	235	2
3	LANDSCAPING	1999	2,079			104	104	269	3
4	LANDSCAPING	1999	2,610			131	131	338	4
5	OVERHANG LOGO	1999	1,750			88	88	227	5
6	DOOR RENOV	1999	2,496			125	125	323	6
7	WINDOW RENOV	1999	845			42	42	109	7
8	RODDING	1999	1,786			89	89	223	8
9	RODDING	1999	1,000			50	50	125	9
10	LANDSCAPING	1999	870			44	44	110	10
11	PLUMBIN	1999	1,800			90	90	225	11
12	RODDING	1999	600			30	30	73	12
13	RODDING	1999	1,223			61	61	147	13
14	INSULATION	1999	780			39	39	94	14
15	PLUMBING	1999	840			42	42	102	15
16	LANDSCAPING	1999	870			44	44	103	16
17	INSULATION	1999	780			39	39	91	17
18	RODDING	1999	549			27	27	63	18
19	DUCT HEATER	1999	1,884			94	94	219	19
20	REDDING	1999	625			31	31	72	20
21	ELECTRICAL RENOV	1999	950			48	48	112	21
22	STEEL DOOR	1999	2,496			125	125	292	22
23	SEWER RENOV	1999	844			42	42	95	23
24	SEWER RENOV	1999	745			37	37	83	24
25	FLOOD CLEANING	1999	2,927			146	146	316	25
26	AQUARIUM RENOV	1999	1,801			90	90	195	26
27	MOTOR RENOV	1999	688			34	34	74	27
28	LANDSCAPING	1999	870			44	44	92	28
29	THERMOSTAT	1999	1,028			51	51	106	29
30	WANDERER SYSTEM	1999	7,956			398	398	896	30
31	3 POLE CONTRACTOR	1999	680			34	34	79	31
32	COMPRESSOR RENOV	1999	621			31	31	72	32
33	RODS	1999	580			29	29	77	33
34	TOTAL (lines 1 thru 33)		$ 10,621,568	$ 309,609		$ 529,908	$ 220,299	$ 2,746,928	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 10,621,568	$ 309,609		$ 529,908	$ 220,299	$ 2,746,928	1
2	WELL TANK	1999	669			33	33	91	2
3	LANDSCAPING	1999	2,326			60	60	60	3
4	PLUMBING RENOV	2000	875			44	44	88	4
5	SEWER RENOV	2000	1,330			67	67	134	5
6	GENERATOR RENOV	2000	551			55	55	110	6
7	CLEANING	2000	3,471			174	174	334	7
8	SEWER RENOV	2000	503			25	25	48	8
9	SEWER INSTALL	2000	8,200			410	410	786	9
10	PLUMBING RENOV	2000	1,370			69	69	132	10
11	BEDSPREADS	2000	1,717			86	86	165	11
12	HOT WATER HEATERS	2000	1,847			92	92	176	12
13	DOORS	2000	2,500			250	250	479	13
14	BEDSPREADS	2000	5,421			271	271	497	14
15	PIPE INSTALLATION	2000	11,000			550	550	963	15
16	RODDING	2000	2,030			102	102	179	16
17	FENCE REPAIR	2000	850			43	43	72	17
18	ELECTRICAL RENOV	2000	885			89	89	148	18
19	BASEMENT FLOOR	2000	34,650			1,733	1,733	2,744	19
20	FIRE ALARM PANEL	2000	4,064			406	406	643	20
21	SIGNS	2000	1,683			84	84	126	21
22	WATER HEATER REPAIR	2000	2,144			214	214	321	22
23	ELECTRIC WIRING	2000	985			49	49	74	23
24	LANDSCAPING	2000	1,200			60	60	90	24
25	LANDSCAPING	2000	2,085			104	104	156	25
26	HVAC REPAIR	2000	595			30	30	43	26
27	RODDING	2000	1,280			64	64	91	27
28	REPAIR & CLEAN DRAPE	2000	920			46	46	65	28
29	BACKFLOW CERTIFICATI	2000	840			42	42	60	29
30	DOORS	2000	1,614			81	81	115	30
31	HVAC REPAIR	2000	698			35	35	50	31
32	INSPECT UNDERGROUND	2000	1,270			64	64	85	32
33	DOOR FRAMES	2000	2,000			100	100	133	33
34	TOTAL (lines 1 thru 33)		$ 10,723,141	$ 309,609		$ 535,440	$ 225,831	$ 2,756,186	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 10,723,141	$ 309,609		$ 535,440	$ 225,831	$ 2,756,186	1
2	OFFICE	2000	3,260			163	163	217	2
3	HVAC REPAIR	2000	638			32	32	43	3
4	HVAC REPAIR	2000	(329)			16	16	21	4
5	3RD FLOOR CORRIDOR	2001	11,766			588	588	588	5
6	CARPETING	2001	20,162			1,008	1,008	1,008	6
7	PUMP	2001	1,175			59	59	59	7
8	PUMP	2001	665			33	33	33	8
9	AMERICAN EAGLE DETEC	2001	1,450			67	67	67	9
10	HVAC REPAIR	2001	887			40	40	40	10
11	FIRE ALARM R&M	2001	2,282			105	105	105	11
12	HOT WATER HEATER	2001	6,520			272	272	272	12
13	AMERICAN EAGLE DETEC	2001	1,450			61	61	61	13
14	AMER EDGE DETECTOR E	2001	1,450			55	55	55	14
15	FENCE REPAIR	2001	562			19	19	19	15
16	BOILER R & M	2001	612			21	21	21	16
17	HOT WATER HEATER	2001	4,564			133	133	133	17
18	HVAC REPAIR	2001	767			22	22	22	18
19	HVAC REPAIR	2001	973			25	25	25	19
20	PLUMBING R&M	2001	625			13	13	13	20
21	INSPECT UNDERGROUND	2001	798			13	13	13	21
22	CLEANOUT SEWER	2001	2,980			50	50	50	22
23	BACKFLOW SERVICE	2001	860			14	14	14	23
24	PAINT	2001	690			6	6	6	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,787,948	$ 309,609		$ 538,255	$ 228,646	$ 2,759,071	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 10,787,948	$ 309,609		$ 538,255	$ 228,646	$ 2,759,071	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,787,948	$ 309,609		$ 538,255	$ 228,646	$ 2,759,071	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 10,787,948	$ 309,609		$ 538,255	$ 228,646	$ 2,759,071	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,787,948	$ 309,609		$ 538,255	$ 228,646	$ 2,759,071	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 10,787,948	$ 309,609		$ 538,255	$ 228,646	$ 2,759,071	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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16									16
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20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,787,948	$ 309,609		$ 538,255	$ 228,646	$ 2,759,071	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 10,787,948	$ 309,609		$ 538,255	$ 228,646	$ 2,759,071	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,787,948	$ 309,609		$ 538,255	$ 228,646	$ 2,759,071	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1996		$ 10,226,094	$ 262,207	35	$ 511,305	$ 249,098	$ 2,670,413	4
5	CCI Alloc				56,721	1,454	35	1,621	167	8,238	5
6											6
7											7
8											8
	Improvement Type**										
9	CARE CENTERS INC			2001	162	21	20	4	(17)	4	9
10	CARE CENTERS INC			2000	68	2	20	3	1	6	10
11	CARE CENTERS INC			1999	1,016	26	20	51	25	147	11
12	CARE CENTERS INC			1998	419	11	20	21	(10)	77	12
13	CARE CENTERS INC			1997	5,949	105	20	328	223	1,918	13
14	CARE CENTERS INC			1996	6,539	86	20	345	259	1,355	14
15	CARE CENTERS INC			1997	690	160	20	30	(130)	97	15
16	CARE CENTERS INC			1994		19	20		(19)		16
17	CARE CENTERS INC			1993		6	20		(6)		17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 10,297,658	$ 264,097		$ 513,708	$ 249,591	$ 2,682,255	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 864,121	$ 63,302	$ 86,656	$ 23,354		$ 447,602	71
72	Current Year Purchases	19,245	487	1,058	571		1,058	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 883,366	$ 63,789	$ 87,714	$ 23,925		$ 448,660	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		CCI ALLOC		$ 27,428	$ 4,197	$ 4,205	$ 8		$ 13,532	76
77										77
78										78
79										79
80	TOTALS			$ 27,428	$ 4,197	$ 4,205	$ 8		$ 13,532	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,953,845	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 377,595	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 630,174	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 252,579	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,221,263	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	CCI ALLOC				6,255			5
6								6
7	TOTAL				$ 6,255 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 8,339 Description: SEE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 47,320	$		$ 47,320	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			13,158			13,158	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			55,554			55,554	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				123,382		123,382	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						76,210		76,210	13
14	TOTAL			$		$ 116,032	$ 199,592		$ 315,624	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 6,640	$ 6,961	1
2	Cash-Patient Deposits	51,952	51,952	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,580,380	1,580,380	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	221,166	221,166	6
7	Other Prepaid Expenses	20,905	20,905	7
8	Accounts Receivable (owners or related parties)		15,170	8
9	Other(specify): See supplemental schedule	2,659,610	2,659,610	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,540,653	$ 4,556,144	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		251,898	13
14	Buildings, at Historical Cost		10,226,094	14
15	Leasehold Improvements, at Historical Cost	428,303	428,303	15
16	Equipment, at Historical Cost	222,183	890,503	16
17	Accumulated Depreciation (book methods)	(201,737)	(2,120,608)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	477	67,722	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 449,226	$ 9,743,912	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,989,879	$ 14,300,056	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 508,704	$ 508,704	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	48,359	48,359	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	235,298	235,298	30
31	Accrued Taxes Payable (excluding real estate taxes)	26,946	26,946	31
32	Accrued Real Estate Taxes(Sch.IX-B)	360,474	360,474	32
33	Accrued Interest Payable		80,674	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	7,000	7,000	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	791,874	5,413	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,978,655	$ 1,272,868	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		12,451,059	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 12,451,059	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,978,655	$ 13,723,927	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,011,224	$ 576,129	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,989,879	$ 14,300,056	48

***(See instructions.)**

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,625,866	1
2	Restatements (describe):		2
3	INCOME TAXES PAYABLE - AJE	24,172	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,650,038	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	465,986	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(104,800)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 361,186	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,011,224	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,342,212	1
2	Discounts and Allowances for all Levels	(842,589)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,499,623	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	631,823	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 631,823	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	115,967	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,090	19
20	Radiology and X-Ray	5,240	20
21	Other Medical Services	162,849	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 302,146	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	175,496	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 175,496	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,609,088	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,763,966	31
32	Health Care	3,071,085	32
33	General Administration	2,160,368	33
	B. Capital Expense		
34	Ownership	1,707,229	34
	C. Ancillary Expense		
35	Special Cost Centers	315,624	35
36	Provider Participation Fee	124,830	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,143,102	40
41	**Income before Income Taxes (line 30 minus line 40)****	465,986	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 465,986	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing	2,925	3,296	76,289	23.15	2
3	Registered Nurses	7,361	8,280	171,746	20.74	3
4	Licensed Practical Nurses	59,506	64,977	1,186,149	18.25	4
5	Nurse Aides & Orderlies	117,590	131,342	1,098,959	8.37	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,233	6,698	77,343	11.55	8
9	Activity Director	1,597	2,084	25,661	12.31	9
10	Activity Assistants	13,865	14,769	103,290	6.99	10
11	Social Service Workers	8,051	9,092	87,688	9.64	11
12	Dietician					12
13	Food Service Supervisor	3,871	4,440	58,009	13.07	13
14	Head Cook	5,185	5,565	48,726	8.76	14
15	Cook Helpers/Assistants	28,261	30,528	216,025	7.08	15
16	Dishwashers					16
17	Maintenance Workers	6,086	6,639	77,647	11.70	17
18	Housekeepers	27,297	29,606	202,224	6.83	18
19	Laundry	11,848	12,965	88,884	6.86	19
20	Administrator					20
21	Assistant Administrator	3,032	3,662	64,361	17.58	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,056	14,531	128,273	8.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,923	2,163	21,091	9.75	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	317,687	350,637	$ 3,732,365 *	$ 10.64	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	968	$ 21,502	01-03	35
36	Medical Director	monthly	9,000	09-03	36
37	Medical Records Consultant	96	4,032	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	120	2,825	10-03	39
40	Physical Therapy Consultant	43	1,400	10a-03	40
41	Occupational Therapy Consultant	54	2,713	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	15	750	10a-03	43
44	Activity Consultant	51	2,424	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	CCI - COSTS	See Attached	85,586	Various	47
48					48
49	TOTAL (lines 35 - 48)	1,347	$ 130,232		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
EDITH BALLARD	ASST. ADMINISTRATOR		$ 41,191
ANTHONY WALKER	ASST. ADMINISTRATOR		23,170
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 64,361

B. Administrative - Other

Description	Amount
CHRIS WAYER	$ 175
MANAGEMENT FEES - SEE ATTACHED	204,000
CCI - ADMINISTRATIVE PAYROLL (Adjusted on P. 6)	74,111
TOTAL (agree to Schedule V, line 17, col. 3)	$ 278,286
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SEE ATTACHED SCHEDULE	ACCOUNTING	$ 49,695
SEE ATTACHED SCHEDULE	LEGAL	40,661
CARE CENTERS	BOOKKEEPING	46,512
SEE ATTACHED SCHEDULE	DATA PROCESSING	17,067
CARE CENTERS	HOME OFFICE EXPENSE	191,520
CARE CENTERS	ANCILARY ADMIN. SERV.	27,360
PERSONELL PLANNERS	UNEMPLOYMENT CONS.	3,247
CARE CENTERS	PROF. FEES (ADJ ON 6B)	11,300
HUNTER MANAGEMENT	SURVEY(ADJ P.5)	1,000
AMERICAN EXPRESS	TAX SERVICE	2,386
AMERICAN EMPIRE GROUP	LAWSUIT FEE	4,447
CARE CENTERS	SEE ATTACHED	7,091
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 402,287

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 98,605
Unemployment Compensation Insurance	70,257
FICA Taxes	283,986
Employee Health Insurance	131,764
Employee Meals	34,821
Illinois Municipal Retirement Fund (IMRF)*	
EMP EXP TAX	11,494
PENSION	1,843
MISC EMPLOYEE WELFARE	7,407
TOTAL (agree to Schedule V, line 22, col.8)	$ 640,177

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	15,386
Health Care Worker Background Check	
(Indicate # of checks performed 218)	7,164
ADVERTISING	17,281
DUES	9,148
LICENSES	8,351
YELLOW PAGES	264
ALLOC CCI	2,281
ALLOC CCI - HEATH SYS.	9
Less: Public Relations Expense	(17,281)
Non-allowable advertising	
Yellow page advertising	(264)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 42,539

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,947
Alloc CCI	1,659
Alloc CCI-Health Sys.	1
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,607

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
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8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL $9148**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,533** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **124,830**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **34,821** Has any meal income been offset against related costs? **NO** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees